Elements CTS LTD

Counselling & Therapeutic Services

Expressive Therapy Mental Health Therapeutic Play Adventure Therapy

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Counselling Referral Form

Date of Referral: _____

Client Information

First Name: _____ Last Name: _____

Date of Birth: _____ Treaty Number: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Permission to contact/leave a message? Yes ○ No ○

Cell Phone: _____ Permission to contact/leave a message? Yes ○ No ○

Email: _____ Permission to contact/leave a message? Yes ○ No ○

Is the client a minor or under 16? Yes ○ No ○

Legal Guardian Name: _____ Phone: _____

Reason For Referral: _____

_____

_____

_____

Type of Service Requested

☐ Individual Therapy ☐ Couples/Family Therapy ☐ Play Therapy

☐ Action Therapy ☐ Land-based Therapy ☐ Other

Payment Type

☐ FNIHB ☐ Jordan's Principle ☐ Victim Services

☐ Agency Agency Name _____ ☐ Other Please Specify _____

Client (if over 16 years of age) or parent/guardian signature

Client or Parent/guardian name:	**Signature:**	**Date:**